Patient Information:

Name: ___________________________ **Health Insurance:** ______________________________________

Date of birth_____/______/______ **Vision Insurance:** ______________________________________

Address: _________________________ **Name of Insured:**____

_________________________________ **SSN of Insured:**____

SSN :____________________________ **Birthday of Insured:** ___________/____________/____________

Email:_____________________________ **Tobacco Use: Yes No Former smoker**

Preferred Language: ______________ **If yes, how long _____ / # of packs_____**

Race: ____________ **Ethnicity:**______ **Alcohol Use: No Yes**

Height:___________**Weight:** ________ **If yes, how many drinks per week______**

Phone : (____) ____________________ **Exposed to or infected with a STD Yes No**

Cell Phone: (____)_________________ **Marital status:** ______________: **Spouse**___________________

Digital retinal imaging is used to track or diagnose abnormal eye conditions. Our fee for this service is $35.

ACCEPT DECLINE SPEAK WITH DR.

Dilation allows a more thorough examination of the eye and is recommended for new patient and diabetic patients.

ACCEPT DECLINE SPEAK WITH DR.

MPOD Screening determines pigment density in your macula. Our fee for this service is $15.

ACCEPT DECLINE SPEAK WITH DR.

Family doctor: __________________________________**Last Visit**: ________________________________

Pharmacy: ____

Please check any conditions that you are currently experiencing or diagnosed with:

Blurred Vision	___	Light Sensitivity	___	Diabetes(Type 1/Type 2)	___
Burning	___	Loss of Vision/Side Vision	___	Emphysema	___
Chalazion or Stye	___	Migraines	___	Fever, Weight loss/Gain	___
Double Vision	___	Mucous Discharge	___	Genitals/Kidney/Bladder	___
Dryness	___	Redness	___	Heart Attack	___
Eye Pain or Soreness	___	Seizures	___	Heart Disease	___
Flashes/Floaters in Vision	___	Tearing/Watering	___	High Blood Pressure	___
Foreign Body/Gritty/Sandy	___	Tired Eyes	___	Joint Pain/Muscle Pain	___
Glare	___	Twitching Eyelid	___	Pregnant / Nursing	___
Halos/Distorted Vision	___	Allergies/Sinus Congestion	___	Psychiatric/Depression	___
Headaches	___	Anemia/Bleeding Problems	___	Stroke	___
Infection (Eye/Lid)	___	Arthritis/Rheumatoid	___	Thyroid/Other Glands	___
Injury/Trauma/Surgery	___	Asthma	___	OTHER Explain_____________	
Itching	___	Chronic Bronchitis	___		

Please list all major injuries, surgeries, and/or hospitalizations_________________________________

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Medication: ____

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____

Seasonal or Medication Allergies: ____

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Patient / Guarantor signature **Date**